STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2009-20130 HHS
Case No. [redacted]
Load No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared and testified on her own behalf. [redacted], represented the Department. [redacted], appeared as a witness on behalf of the Department and [redacted] also appeared as a witness on behalf of the Department.

ISSUE

Did the Department properly terminate Home Help Services payments to the Appellant?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a Medicaid beneficiary and participant in Home Help Services (HHS).

2. The Appellant suffers insulin resistant diabetes, hyperlipidemia, neuropathy, macular degeneration, high blood pressure and depression.

3. The Appellant is ambulatory, however, also has use of an electric scooter for inside and outside of her home.

4. The Appellant's home is modified for use by someone in a wheelchair or scooter.

5. The Appellant's case was transferred to a different Department worker, prompting a spontaneous visit to her home on [redacted].

6. While in the Appellant's home, the worker observed the Appellant was neatly dressed and properly groomed. The Appellant's home was neat and clean.

7. The worker learned from the Appellant that she had cleaned her home herself.

8. The Appellant was preparing food for herself at the time the worker made the unannounced visit to her home.

9. The Appellant was able to go to her bedroom and for the purpose of getting her calendar.

10. The Appellant has not had a Department of Community Health paid provider from the HHS program since at least [redacted] She fired the last proposed provider within 2 hours.

11. The worker determined the Appellant did not require physical assistance in order to maintain independent living in her own home.

12. The worker sent a negative action notice dated [redacted].

13. The Negative Action Notice purported to have an effective date of [redacted].

14. The Appellant appealed the Department determination [redacted].

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Home Help Services (HHS) are provided to enable functionally limited individuals to live independently and receive care in the least restrictive, preferred settings. These activities must be certified by a physician and may be provided by individuals or by private or public agencies.

COMPREHENSIVE ASSESSMENT

The Adult Services Comprehensive Assessment (FIA-324) is the primary tool for determining need for services. The comprehensive assessment will be completed on all open cases, whether a home help payment will be made or not. ASCAP, the automated workload management system provides the format for the comprehensive assessment and all information will be entered on the computer program.

Requirements for the comprehensive assessment include, but are not limited to:

- A comprehensive assessment will be completed on all new cases.
- A face-to-face contact is required with the customer in his/her place of residence.
- An interview must be conducted with the caregiver, if applicable.
- Observe a copy of the customer's social security card.
- Observe a picture I.D. of the caregiver, if applicable.
- The assessment must be updated as often as necessary, but minimally at the six-month review and annual re-determination.
- A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the agency record.
- Follow specialized rules of confidentiality when ILS cases have companion APS cases.

Functional Assessment

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the HHS payment.

Conduct a functional assessment to determine the customer's ability to perform the following activities:

Activities of Daily Living (ADL)

- Eating
- Toileting
- Bathing

- Grooming
- Dressing
- Transferring
- Mobility

Instrumental Activities of Daily Living (IADL)

- Taking Medication
- Meal Preparation and Cleanup
- Shopping for food and other necessities of daily living
- Laundry
- Housework

Functional Scale ADL's and IADL's are assessed according to the following five-point scale:

1. Independent
   Performs the activity safely with no human assistance.

2. Verbal Assistance
   Performs the activity with verbal assistance such as reminding, guiding or encouraging.

3. Some Human Assistance
   Performs the activity with some direct physical assistance and/or assistive technology.

4. Much Human Assistance
   Performs the activity with a great deal of human assistance and/or assistive technology.

5. Dependent
   Does not perform the activity even with human assistance and/or assistive technology.

Note: HHS payments may only be authorized for needs assessed at the 3 level or greater. Customers must require assistance with at least one qualifying ADL in order to qualify for HHS payments. A qualifying ADL (functionally assessed at Level 3 or greater) would include:

- An ADL functional need authorized by the worker

- An ADL accomplished by equipment or assistive technology and documented by the worker, or
- An ADL functional need performed by someone else, requiring no Medicaid reimbursement, or
- A request authorized as necessary through an exception made by the Department of Community Health, Central Office.

Once an ADL has been determined or exception request has been granted, the customer is then eligible for any ADL or IADL authorized home help service.

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ELIGIBILITY FOR HOME HELP SERVICES

Home help services (HHS) are defined as those, which the Agency is paying for through Title XIX (Medicaid) funds. The customer must be eligible for Medicaid in order to receive these services.

Medicaid/Medical Aid (MA)

Verify the customer's Medicaid/Medical aid status.

The customer may be eligible for MA under one of the following:

- All requirements for MA have been met, **or**
- MA spend-down obligation has been met.

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Necessity For Service

The adult services worker is responsible for determining the necessity and level of need for HHS based on:

- Customer choice.
- A complete comprehensive assessment and determination of the customer's need for personal care services.

- Verification of the customer's medical need by a Medicaid enrolled medical professional. The customer is responsible for obtaining the medical certification of need. The Medicaid provider identification number must be entered on the form by

> the medical provider. The Medical Needs form must be signed and dated by one of the following medical professionals:
>
> - Physician
> - Nurse Practitioner
> - Occupational Therapist
> - Physical Therapist
>
> The physician is to certify that the customer's need for service is related to an existing medical condition. The physician does not prescribe or authorize personal care services.

In this case the material facts are disputed. Appellant asserts she is physically unable to perform many of her own ADL's and IADL's whereas the Department's Adult Services Worker believes she is able to provide for her own care. The evidence offered by Appellant that she is physically unable to provide for her own care is sparse. She testified she had not cleaned her own home. Then she admitted she had but asserted it came at great cost to her physically. She stated she suffered a lot of pain as a result of performing her own chores. She also asserted she has personal assistance rendered from a separate program paid with Medicare funding, thus she has not really been without a provider. She also asserted her freezer had "gone out", thus creating a need to cook all of her food. She did not dispute she is able to walk. She further asserted she has a new physical problem with her hands.

The Department's witness asserts when she was present for the home call the Appellant never asserted anyone had assisted her with the housework. She had remarked on what a great job she had done herself, in fact. She was asked if each of the tasks had been discussed. She stated they had not. Specifically, she had not ascertained how laundry had been accomplished, nor cleaning of floors. She simply stated the house was clean and she had not paid a provider so it was obvious to her a provider was not needed.

This ALJ reviewed the evidentiary record to determine if the Department's decision must be reversed. The Appellant damaged her own credibility by asserting she had assistance with her home and then informing her worker she had done it herself. Additionally, she wrote on her hearing request she had done it herself but then stated at hearing she had help. Her testimony is not reliable, thus cannot be given persuasive or controlling effect. The burden of proof rests with the Appellant to establish the Department's determination was incorrect. She did not provide sufficient credible evidence she requires physical assistance in order to remain independent in her own home. That is the goal of the program. Given the lack of credible evidence Appellant is in need of human physical assistance to perform ALD's and IADL's, this ALJ finds the Department properly terminated Appellant's HHS payments.

Regarding the Appellant's assertion of a new physical problem with her hands, this is evidence of a new physical condition. There was no evidence that was considered

when the Department made the determination to terminate her services. Should she obtain medical evidence regarding limitations with her hands such that she requires physical assistance in order to remain independent in the community, she is free and encouraged to re-apply for this program. A new assessment will be completed upon a new application for services.

This ALJ must note the proposed termination date of the Advance Negative Action Notice was legally inadequate to provide Advance Notice of the Department action. At least 10 days notice is required in order to meet the legally mandated negative action notice requirements. Here, as no services were being provided, no provider employed by the Appellant and no payments had issued since [redacted], there was no actual harm befallen the Appellant. The purpose of discussion in this Decision and Order is to apprise the Department that the legal requirements are still in place.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly terminated Appellant's HHS payments.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

_____

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: _____

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.